Eritrea

Final Country Report

January 2000

The goal of the Family Planning Service Expansion and Technical Support (SEATS) Project is to expand access to and use of high-quality, sustainable family planning and reproductive health services.

John Snow, Inc. (JSI), an international public health management consulting firm, heads a group of organizations implementing the SEATS Project. These include the American College of Nurse-Midwives (ACNM), AVSC International, Initiatives, Inc., the Program for Appropriate Technology in Health (PATH), World Education, and partner organizations in each country where SEATS is active.

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Acronyms

ACNM	American College of Nurse-Midwives
AIDS	Acquired Immune Deficiency Syndrome
BASICS	Basic Support for Institutionalizing Child Survival Project
CA	Cooperating Agency
CHA	Community Health Agent
CMS	Central Medical Stores
CQI	Continuous Quality Improvement
CYP	Couple-years of Protection
DHS	Demographic and Health Survey
EHP	Eritrean Health and Population Project
FGC	Female Genital Cutting
FP	Family Planning
FPLM	Family Planning Logistics Management Project
GDP	Gross Domestic Product
GOE	Government of Eritrea
HIS	Health Information System
HIV	Human Immunodeficiency Virus
IEC	Information, Education, and Communication
IPCC	Interpersonal Communication and Counseling
IUD	Intrauterine Device
KAP	Knowledge, Attitudes and Practices
LMIS	Logistics Management Information System
LSS	Life-saving Skills
MAQ	Maximizing Access to Quality
MCH	Maternal and Child Health
MIS	Management Information System
MOE	Ministry of Education
MOH	Ministry of Health
NGO	Non-governmental Organization
NUEW	National Union of Eritrean Women
NUEYS	National Union of Eritrean Youth and Students
OMNI	Opportunities for Micronutrient Interventions Project
PATH	Program for Appropriate Technology in Health
PHC	Primary Health Care
PPAE	Planned Parenthood Association of Eritrea
PSI	Population Services International
PVO	Private Voluntary Organization
QA	Quality Assurance
QIQ	Quick Investigation of Quality
QOC	Quality of Care
RH	Reproductive Health
SDP	Service Delivery Point
SEATS	Family Planning Service Expansion and Technical Support Project

SMTAC	Safe Motherhood Technical Advisory Committee
STI	Sexually Transmitted Infection
TBA	Traditional Birth Attendant
TFR	Total Fertility Rate
TNA	Training Needs Assessment
TOT	Training of Trainers
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
URC	University Research Corporation
USAID	United States Agency for International Development
WHO	World Health Organization
WRA	Women of Reproductive Age
ZHMT	Zonal Health Management Team

I. EXECUTIVE SUMMARY

Eritrea, Africa's newest nation, gained independence in May 1991 after a bloody thirty-year war with Ethiopia. Independence was formally declared on May 24, 1993 following a referendum in which over 99 percent of the people voted for autonomy.

The United States Agency for International Development (USAID)/Eritrea and the Ministry of Health (MOH)/Government of Eritrea (GOE) carried out a family planning and reproductive health needs assessment in June 1995 which resulted in the development of a five-year (1996-2001) bilateral project, the Eritrean Health and Population (EHP) Project. The EHP Project's goal was to increase the use of sustainable, integrated primary health care (PHC) services by Eritreans to improve their health status, with particular emphasis on the health of women and young children. The MOH was eager to implement the program, including the management of technical assistance through Cooperating Agencies (CAs) and technical advisors.

The Family Planning and Service Expansion and Technical Support (SEATS II) Project, implemented by John Snow, Inc., was one of the CAs selected by the MOH (with USAID guidance) to provide technical assistance in family planning (FP) and reproductive health (RH) to the EHP Project. The process of identifying and prioritizing assistance needs was firmly in the hands of the MOH and, although a three-year SEATS II Eritrea Country Plan was developed, the nature of SEATS' assistance and participation would change over time as the EHP Project unfolded and the needs of the MOH evolved.

The general parameters of SEATS' assistance were outlined under three major activities supporting the EHP Project:

- **The Every Opportunity: Eritrea Family Planning Service Delivery Subproject** was designed to increase knowledge of, access to and use of FP/RH services among Eritrean women and youth and to foster the integration of FP/RH into primary health care (PHC) and community health services throughout the country.
- **The Access for Youth to Family Planning/Reproductive Health Service Delivery Subproject** was designed to improve the health status of Eritrean youth through collaboration with the National Union of Eritrean Youth and Students (NUEYS).
- **The Safe Motherhood (SM) Initiative** was designed to improve the health status of Eritrean children and women of reproductive age by building upon and strengthening the existing MOH RH programs.

Tremendous challenges faced the health sector. Much of the rural population lives far from service delivery points (SDPs), many of which had been destroyed or damaged in the war. The rugged geography of the country heightens problems of access; cultural and religious barriers to FP are prevalent; health workers were largely untrained in FP; and contraceptive logistics procurement, management and distribution was very weak.

Notwithstanding these challenges, the SEATS activities were implemented with a great deal of success. Renewed border conflict with Ethiopia and the subsequent evacuation of expatriate advisors hampered timely completion of all planned activities, but nonetheless, significant strides

were made in the areas of access to and the quality and sustainability of family planning and reproductive health services. Important advances were made in clinical skills; information, education and communication (IEC); management systems; and institutional capacity building. Collaboration with national level partners and international agencies, as well as other CAs, enhanced the results of activities, and important lessons were generated with implications for future FP/RH planning and programming in Eritrea.

Most important, the leadership, growing awareness, knowledge and commitment of the MOH and other government officials suggest continuing improvements and progress for the future.

II. PROJECT BACKGROUND

A. Country Background

Eritrea is a relatively poor country among the developing sub-Saharan countries with a gross domestic product (GDP) estimated at US $ 150 per capita. The population of approximately 3.5 million people is almost evenly split between Christians (predominantly Orthodox) and Muslims. There are nine different ethnic groups, with *Tigrigna* and *Tigre* the most prominent (50 percent and 31 percent respectively). A national census has not yet been done, but estimates indicate a population of about 3 million. The population is largely rural, with 70 percent living in rural areas and 30 percent in urban centers.

The Eritrean terrain ranges from a rugged, mountainous central region to the arid desert region along the Red Sea coast and the dry lowlands in the west. The many years of recurrent war and pastoral life have severely deforested and eroded the environment. Extremes of temperatures, the rugged terrain, and a limited paved road network make communication to most of the rural areas difficult. Eritrea is divided into six administrative *zobas* (zones); SEATS activities were focused on the three USAID priority zones: Gash Barka, Debub and Maekel. (See Appendix I. Map of Eritrea)

B. Demographic and Health Indicators

According to the 1995 Eritrean Demographic and Health Survey (DHS), the total fertility rate (TFR) was 4.23 for urban areas and 6.99 for rural areas. About two thirds of women knew of at least one FP method, but only 4 percent of women of reproductive age (WRA) who wanted to postpone pregnancies were using a modern method. About 70 percent of married women expressed a desire to space or limit births. This unmet demand for family planning services called for improvements in access to and quality of the service delivery system.

Eritrea has a relatively young population, with those under 14 years of age constituting 46 percent. Early marriage is common. The women in some ethnic communities marry as early as 12-13 years of age and an estimated one-quarter of the women nationwide are married by the age of 15 years.

The WRA, representing approximately 20 percent of the population, comprise an especially vulnerable group. The maternal mortality ratio at 998/100,000 live births is one of the highest in the world. Only 17 percent of deliveries occur in health institutions and only 21 percent are attended by a trained provider. Other factors affecting women's health are poor nutritional status; low literacy rates for women (20 percent); and cultural practices which disfavor women's health, such as female genital cutting (FGC) which affects 95 percent of women.

C. The Eritrean Health Care System

Under the guidance of the GOE, the MOH is responsible for developing and implementing health care policy to improve the health status of all Eritreans. Within the MOH, there are five Divisions, headed by Directors reporting to the Director General of Health Services, who is directly accountable to the Minister. At the zone level, the Zonal Medical Officer is responsible for services.

There are national referral hospitals in the capital, Asmara, providing specialized curative services. In the zones, hospitals are staffed by general physicians, but attempts are underway to identify and place specialists. Health centers within zones are responsible for 50,000 people and have maternity services in addition to outpatient services. Some have limited in-patient facilities. They are staffed by nurses and midwives. Health stations are the lowest level of the formal health service, each responsible for around 10,000 people. Health assistants work at all levels of the health system, but are primarily in charge of health stations.

At the community level, traditional birth attendants (TBAs) and community health agents (CHAs) provide health services. Many TBAs and CHAs, however, are not active due to lack of clear supervisory mechanisms. In some areas, TBAs collaborate with health facilities by visiting them for continuing education and by referring women with complications in pregnancy and labor.

At independence, most of the health facilities in the country had been damaged or destroyed by many years of war. The health infrastructure that did exist was not available to many people. Less than 40 percent of the population lived within 5 kilometers of a health facility in 1995 due to the dearth of facilities and widely dispersed villages.

While a serious health staff shortage exists in Eritrea, the existing staff tends to be hard working and dedicated to public service. The limited number of health personnel at times results in inadequate supervision and weak referral systems within the different levels of services. In 1995, it was noted that there was a need to improve and maintain the quality of reproductive health services and enhance the availability of family planning services, while expanding the method mix to include long-term methods. Many facilities did not maintain registers, client cards or summary sheets to enable quality client management, program tracking or logistics management.

In 1995, the health logistics system was inadequate and did not ensure against stockouts of drugs and supplies. Essential drugs were supplied periodically, not on demand but by a push system based on criteria set by the MOH. Contraceptives were not integrated into the drug logistics system. A great need existed to develop and streamline the supply and inventory control system. A strengthened logistics management information system (LMIS) was needed to guard against stockouts and ensure a wider method choice for clients.

III. GOALS AND OBJECTIVES

A. Government of Eritrea

Due to a growing awareness of the impact of high fertility and population growth on infrastructure and a fragile environment, the GOE addressed RH issues by establishing policy guidelines and formulating a national population strategy. Progressive primary health care and sexual/reproductive health policy guidelines were developed by the MOH in May 1996. The guidelines address the integration of services, development of institutional and technical capabilities and sustainability.

The aim of the PHC policy guidelines is to achieve "essential care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-reliance and self determination; it is the first level of contact of individuals, the family and the community with the national health system, bringing health care as close as possible to where people live and work."

The sexual and RH policy guidelines aim to ensure that all individuals and families have access to fully-integrated, quality reproductive and sexual health services through governmental and NGO facilities and community-based health services; to increase the proportion of women who have access to information on reproductive health and who are using an effective method of contraception; and to ensure that women freely choose the number and spacing of their children.

B. USAID/Eritrea

USAID/Eritrea's program is guided by its Strategic Objectives and Intermediate Results (IRs). SEATS' work in Eritrea contributes to Strategic Objective 1: **"Increased Use of Sustainable Integrated Primary Health Care Services by Eritreans."** This Objective is consistent with the overall USAID Population, Health, and Nutrition Center's goal of stabilizing population and protecting human health in a sustainable fashion.

SEATS' work in Eritrea, as a component of the bilateral EHP Project, also contributes to the EHP's two major interrelated results which address principal constraints to providing high-quality basic health services. These are:

- Women and children's access to integrated PHC services improved (IR 1)
- Client knowledge and demand for PHC services enhanced (IR 2)

Related to these are three sub-results to which SEATS contributed: improved delivery of integrated PHC services (IR 1.3), enhanced MOH capacity to design and disseminate IEC messages (IR 2.1) and increased knowledge of key child and reproductive health services (2.2).

IV. SEATS' COUNTRY STRATEGY AND PROGRAM

A. Country Strategy

In collaboration with the MOH and USAID/Eritrea, SEATS developed a country strategy with the following objective:

> **To bring about sustained improvement in the health status of the population, with particular emphasis on the health of women, youth, and children.**

The strategy was implemented through technical and financial assistance, training and organizational development assistance characterized by:

- flexibility
- phased implementation
- partnerships with national organizations
- provision of material and technical resources
- integration of FP into existing MCH services
- collaboration with other Cooperating Agencies

SEATS' strategy responded to the MOH objective **to increase the proportion of the women who have access to information on RH and who are using an effective method of contraception.** It aimed to contribute to the national plan to ensure access to affordable, quality RH services. The flexibility designed into SEATS' strategy ensured that, as MOH priorities emerged, shifted or evolved, SEATS could be responsive to new needs and requirements.

B. Country Program

SEATS' activities were programmed as three components supporting the EHP Project: the Every Opportunity: Eritrea Family Planning Service Delivery Subproject; the Access for Youth to Family Planning/Reproductive Health Service Delivery Subproject and the Safe Motherhood Initiative.

1. The Every Opportunity: Eritrea Family Planning Service Delivery Subproject

This subproject was designed to integrate RH and FP services into the PHC system. General goals were to increase knowledge of, access to and use of FP/RH services among Eritrean women and youth and to foster integration of services throughout the country. Interventions included training of MOH staff focusing on basic FP/RH skills and quality of care (QOC); design of IEC strategies and materials; collaboration with NUEYS; strengthening the MOH capacity to develop and utilize logistics and management information systems; renovating and improving SDPs; and long and short term technical assistance.

2. The Access for Youth to FP/RH Service Delivery Subproject

The National Union of Eritrean Youth and Students is a national, democratic and independent organization with priorities, policies and programs in education, training, health, environment, recreation and job placement for youth. NUEYS is a well-staffed organization with an infrastructure that spans the country. It has approximately 180 staff, 30 offices and 100,000 members. NUEYS enjoys support from the Eritrean people and the GOE. It has significant potential to promote change in the knowledge and behavior of Eritrean youth.

The SEATS activities undertaken with NUEYS were based in four sites – the three USAID target zones (including NUEYS youth recreation centers) and the Sawa National Military Training Camp. It is mandatory in Eritrea for youth between 18 and 35 years of age to spend at least 18 months in military training. Twice a year, some 25,000 youth gather at Sawa Camp for six months of military training. This provides an excellent opportunity to reach youth with information and education on reproductive health, including human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) prevention.

The primary goal of the NUEYS component was to "bring about sustained improvement in the health status of Eritrean youth." Interventions included IEC activities, peer counselor and provider training, capacity building and material support.

3. The Safe Motherhood Initiative

The Safe Motherhood Initiative was designed to help the MOH mobilize a Safe Motherhood Technical Advisory Committee (SMTAC) with membership from the United Nations and other agencies involved in reproductive health in Eritrea. The Committee was expected to develop a national five-year strategy for safe motherhood; advocate to reduce maternal mortality; conduct training; provide appropriate medical equipment; work with the IEC unit of the MOH in the design and production of materials; and work with NUEYS on using innovative IEC strategies for safe motherhood and sexually transmitted infections (STIs)/AIDS. SEATS was asked to work with the SMTAC and with the MOH to upgrade the quality of maternity care using a continuous quality improvement (CQI) approach and to help strengthen logistics and management information systems. While the SMTAC itself was never formally established, various task forces and working groups took responsibility for these safe motherhood activities with considerable support from SEATS.

SEATS II began work in Eritrea in March 1996. Working in the three USAID focus zones and, more specifically, in ten selected subzones, SEATS collaborated with Basic Support for Institutionalizing Child Survival Project (BASICS), Opportunities for Micronutrient Intervention (OMNI), Population Services International (PSI) and the MOH in implementing integrated PHC. The program included:

- training of zonal and subzonal health staff in FP/RH
- improvement/equipping of 46 service delivery points
- development of curricula and protocols to guide quality FP/RH training and service delivery
- strategic planning and formative research on eradication of FGC in cooperation with NUEYS, Program for Appropriate Technology in Health (PATH) and MotherCare

- work with NUEYS in advocacy and IEC
- development of contraceptive logistics and management information systems (MIS)

In January 1998, SEATS' role was expanded to help implement the Safe Motherhood Initiative designed to build upon and strengthen the MOH RH programs already supported by SEATS.

Distinctions between the three components previously described were primarily administrative, as technical support and interventions frequently addressed more than one component. Throughout, implementation was guided and managed by the MOH. The result was a constantly evolving program that was not clearly divided into separate subprojects, but which addressed technical issues that cut across various parts of the health sector and the EHP Project. The major technical areas addressed by SEATS in its service to the MOH included:

- policy development
- training
- IEC
- youth
- service delivery systems

The remainder of this report focuses on SEATS' technical interventions and overall support to the MOH.

V. IMPLEMENTATION: TECHNICAL SUPPORT AND INTERVENTIONS

A. Policy Development

With independence, the GOE faced new and daunting challenges. In addition to restoring the country's infrastructure, new policies and operating systems needed to be defined across every sector and level of government. Mechanisms for working with groups – both external and internal – needed to be developed. Internal relationships too, such as those between government and local NGOs, needed to be established and made functional. In its efforts to work carefully and effectively, the GOE retained a very high level of management and decision-making control over all development inputs and activities, including those in the health and population sector. As a result of the GOE's diligence and active participation, SEATS had the opportunity to work closely with MOH officials as they developed and refined policies for family planning and reproductive health.

A high priority for the MOH was to operationalize its policy of integrated PHC throughout the country and, as one element of this policy, SEATS assisted the MOH in addressing quality of care. The MOH adopted the principles of QOC and determined that elements of it must be included in all programs from the earliest planning stages.

With SEATS assistance, a National Quality Assurance (QA) Committee with representatives from all departments and divisions of the MOH was created and charged with providing leadership and direction for the implementation of QA in health service delivery. The committee's tasks included designing and institutionalizing a QA system; overseeing the development and dissemination of standards of care; guiding the development of approaches to measure progress toward quality improvement; and ensuring that appropriate training and capacity-building took place. The National QA Committee was given oversight over zonal QA Committees. Facility-based QA teams were also formed.

Supporting the National QA Committee was a National Quality Assurance Technical Subcommittee charged with the day-to-day implementation of the National QA Committee's agenda, including the monitoring and evaluation of QA initiatives in the health sector.

The MOH put policies and systems into place to institutionalize CQI. In mid-1999, it adopted policies and guidelines recognizing the two-pronged nature of quality of care articulated in SEATS' quality strategy, namely quality in fact and quality in perception.

The far-reaching results of these activities are discussed in the next section (VI. Accomplishments and Constraints).

B. Training

Over 1,800 service providers received training from SEATS in Eritrea.

1. FP/RH Training

SEATS was charged with providing training in FP/RH to all health workers delivering MCH services in the SEATS sub-zones through structured and on-the-job training. SEATS' assistance ranged from curriculum and protocol development to the design of training courses for all levels of the healthcare system including nursing and midwifery schools, health facilities and the community.

Basic training in family planning was a high priority. A national four-week FP training curriculum for nurses and nurse-midwives was developed and 19 nurse-midwives were trained as trainers. Using this curriculum, a total of 69 nurses and nurse- midwives were initially trained. During the first two weeks, theoretical aspects of FP service delivery, the management and prevention of reproductive tract infections and the anatomy and physiology of reproductive systems were covered. During the following two weeks, trainees had practical sessions under the supervision of trainers and instructors from the schools of nursing and midwifery in high client flow clinics in Asmara that had been upgraded by SEATS. The practical training included clinical training in IUD insertion and management. The curriculum is now available for ongoing use by the schools.

A three-week FP curriculum for health assistants was also developed and delivered to 75 trainees. Participants spent the first portion of the training covering theoretical aspects of FP services and the latter potion in practical sessions at the upgraded clinics. The health assistants were trained in counseling for all methods and to refer clients elsewhere for services not offered at their clinics.

Together, SEATS and the MOH designed checklists for objective post-training follow-up supervision, and a quarterly support visit system was put in place. Over 86 percent of the FP-trained staff were followed up. Trainees whose performance was found to be of good quality were commended; those whose skills needed further strengthening were given individualized attention.

In addition to basic FP training, SEATS provided technical assistance for integrated PHC training at the central zone and supported interpersonal counseling and communication (IPCC) training (initially provided by BASICS) for senior MOH staff from the national referral hospitals. In total, over 400 service providers nationwide were trained in IPCC through the collaborative efforts of SEATS and BASICS.

2. Safe Motherhood Training

Training provided under the Safe Motherhood Initiative sought to increase the competency of facility-based providers and traditional birth attendants in assessment, referral and management of antenatal and obstetric cases. A taskforce with members from SEATS, United Nations Population Fund (UNFPA), the MOH, the schools of nursing and midwifery, and local obstetricians was formed. The taskforce had the initial responsibility of reviewing the training needs of various cadres of health professionals in Eritrea and designing training guides that would lead to improvements in maternal care at service sites.

A training needs assessment (TNA) was done by the MOH, representatives of the nursing and midwifery schools and SEATS in February and March 1999. The assessment was designed to

determine the level of essential obstetric care available in rural health facilities and the training level of staff that provide midwifery services in the facilities. The TNA also evaluated the equipment required for quality obstetric care and life-saving skills (LSS) training.

The MOH identified and established LSS training centers at two hospitals in Asmara - Edaga Hamus Mini Hospital and Maitemenay National Maternal Referral Hospital. An LSS curriculum was developed and adapted from the Life-saving Skills Manual for Midwives of SEATS partner, the American College of Nurse-Midwives (ACNM). Ten MOH staff and two practicing midwives were trained as trainers using this curriculum which covered maternal mortality in Eritrea and the role of the midwife; management of antenatal care; use of partographs in monitoring the progress of labor; repair of episiotomies and lacerations; prevention and management of hemorrhage (antepartum and postpartum); neonatal resuscitation; prevention and treatment of sepsis; prevention of dehydration during labor and its management when it occurs; vacuum extraction and management of other emergencies like post-abortion care. Discussions are underway between the MOH, SEATS and UNFPA to make LSS a countrywide program.

A national safe motherhood resource center was established at Maitemenay National Maternal Referral Hospital and equipped with furniture, audio- visual aids and reference materials. It is used for the training of physicians posted to the rural hospitals who currently undergo a six-month apprenticeship training at this hospital in the management of obstetric emergencies.

To further enhance safe motherhood training, SEATS supported the MOH to consolidate and adapt all the technical information needed for development of the National Safe Motherhood Clinical Management Protocol. The Protocol was printed and 2,000 copies were distributed by the MOH to regional health offices and health facilities.

During LSS training, each participant was provided with a copy of the National Safe Motherhood Clinical Management Protocol. Competency-based training in the Protocol and LSS was done in nine sessions for 79 midwives drawn from all three USAID focus zones and the schools of midwifery and nursing in Asmara. Further orientation sessions on safe motherhood and LSS were held for 146 health staff in three large hospitals in Asmara.

The Maternal and Child Health (MCH) Coordinator in each zone was designated to provide supervision of the LSS and FP-trained staff. Checklists were used to make supervision objective. Discussions were held with the MCH Coordinators to help make them more responsive to safe motherhood needs within their zones.

In addition to professional school and facility-based training, community level training in safe motherhood was extremely important to the MOH. SEATS was part of the national team that designed a TBA training curriculum to provide the TBAs with skills in safe delivery, assessment and early referral of high-risk women, recognition and referral for complications, emergency first aid, breastfeeding and well baby care. Community level efforts included the pilot training of 143 TBAs from seven subzones in home-based LSS. SEATS provided protective eyewear and delivery kits for the TBAs. Efforts to expand this training countrywide are underway.

C. Information, Education and Communication

Objectives under all of the SEATS program components included increasing the awareness, knowledge of and demand for FP/RH services. Activities included support for conferences, workshops and community meetings; strategy development; formative research; and procurement, production and dissemination of appropriate materials.

1. Conferences/Workshops/Community Meetings

With SEATS support, the National Safe Motherhood Conference in 1996 devoted attention to issues of FGC. As a result, three Eritrean professionals - a gynecologist and two NUEYS staff – participated in a FGC study tour to the Kenyan FGC control programs. Subsequently, a Communication for Change Workshop was held in Eritrea in which religious leaders, bilateral and multilateral organizations, NGOs, association representatives, the University of Asmara and others participated and pledged their commitment to fight FGC at individual and organizational levels.

On World Health Day in 1998, a symposium was organized by the MOH with assistance from WHO, SEATS, and UNFPA in which the maternal mortality problem in Eritrea was presented. SEATS designed and distributed a brochure on safe motherhood and a leaflet on danger signs in high-risk pregnancies.

SEATS provided financial and technical support to the MOH to hold a National IEC Conference in 1999. The objectives of this conference were to introduce 39 high level officials of the MOH and key partner agencies (e.g., the Ministries of Information and Education, UNICEF, UNFPA, WHO) to IEC processes; review the status of health communication in Eritrea; and make recommendations to enhance health promotion in the country. Coordinating the use of media to advocate for behavior change in a number of areas including safe motherhood was a key topic of the conference.

SEATS participated in the annual planning meetings for the zones in 1997, 1998 and 1999. In all zonal planning meetings, reproductive health issues, especially safe motherhood and emergency obstetrics, were featured as the major conditions requiring intervention. As a result of participation in the planning meetings, SEATS supported many community-based IEC efforts. Two examples:

- Community safe motherhood sensitization workshops were conducted in the Maekel and Debub zones, where 200 local administrators, religious leaders, educational leaders, other community leaders and TBAs attended. Topics included maternal mortality status and causes in Eritrea; what could be done to lower the current mortality trends; the roles of communities and various agencies in lowering maternal morbidity and mortality; and recommendations on how to start addressing the problem.
- Sensitization activities were implemented in Debub zone by the office of the zonal medical officer. SEATS provided a TV and video on safe motherhood. Seventeen villages (about 1,500 people) were reached in this effort.

2. Strategy Development

With SEATS technical and financial support, the MOH developed a safe motherhood communication strategy in 1999. Priority behaviors needing attention for communication efforts were identified. Among the safe motherhood priorities, a FGC eradication communications strategy highlighting the health risks of the procedures was designed. The MOH program departments, the zonal health offices and key partners (the Ministries of Information and Education, UNICEF, UNFPA, and WHO) were involved.

3. Formative Research

SEATS supported formative research on several aspects of safe motherhood. With assistance from PATH and MotherCare, SEATS coordinated a knowledge, attitudes and practices (KAP) study on FGC which NUEYS and University of Asmara staff implemented.

A KAP study on antenatal care, family planning and delivery was conducted in four zones. The study included questions on danger signs and behaviors associated with pregnancy and labor. An analysis of this study and others was presented at a later workshop to design a communications strategy for safe motherhood.

4. Materials

SEATS worked closely with the IEC unit of the MOH to identify and assess the appropriateness of the existing IEC materials in country. New materials on FP/RH were procured or produced locally and distributed to health facilities. Health professionals in all 257 facilities across the country providing FP/RH are currently using those IEC materials to provide information and education to the public. Assisted by the MOH, Ministry of Education radio programs include FP and RH issues in their public broadcasts.

In addition to work with the MOH, SEATS participated in the National Union of Eritrean Women (NUEW) committees to design and develop basic informational materials on women's health, including FP.

Materials produced and disseminated in Eritrea with SEATS assistance include:

- laminated guides for counseling on FP and nutrition in pregnancy: 2,000 copies were produced and distributed to all 257 health facilities in the country
- a leaflet on Eritrean maternal mortality:10,000 leaflets were produced and distributed at the 1998 World Health Day celebrations
- a booklet (mainly pictorial) on safe motherhood: 20,000 copies were distributed to community members throughout Eritrea
- a video documentary on the causes of maternal mortality based on actual case studies of maternal deaths in Eritrea: this video was presented at the National Safe Motherhood Workshop held in 1996

In addition to producing printed material, the MOH in collaboration with SEATS, OMNI, UNFPA and BASICS conducted a workshop for scriptwriters of radio materials in 1998. As a result, a 15-part radio serial drama was developed. The serial focused on health and safe motherhood issues

including antenatal clinic attendance, nutritional needs of expectant women and children, and the danger signs that may occur in high-risk pregnancies. The drama was aired on national radio for eight months of 1999. In late 1999, SEATS and the MOH collaborated again to create another radio serial drama which will be aired in 2000.

Special IEC materials targeting youth were a major emphasis of SEATS' work with NUEYS. Over 85,000 youth were reached with FP/RH information at Sawa Camp and at youth centers through audiovisual materials procured by SEATS. For example:

- Using resources at the IEC Unit of the MOH, SEATS and NUEYS health center staff developed leaflets on family planning and STI/HIV/AIDS. More than 56,000 leaflets were printed and distributed to the youth at Sawa Camp and to youth centers in various zones of the country. In addition, over 2,000 posters addressing HIV/AIDS and FGC were distributed at Sawa Camp and in the three USAID focus zones.
- Video films on HIV/AIDS, FGC, causes of maternal mortality, and unwanted pregnancy were provided by SEATS and shown at Sawa Camp to the military trainees, peer counselors, and to youth seeking counseling/treatment. Films were distributed to all NUEYS branch offices in the USAID focus zones and to the NUEYS health center.

D. Youth

SEATS' assistance to NUEYS was designed to increase the availability of information and services in reproductive health for adolescents and to increase access to and use of FP/RH services among sexually active youth. The original program design was much larger than what was actually implemented by SEATS because UNFPA agreed to fund a nationwide youth program based on the SEATS design. This leveraging of resources allowed SEATS to cut back significantly on support to NUEYS and apply those resources elsewhere. SEATS' support to NUEYS included the following:

- SEATS supported the design of messages to be used in music and drama to transmit information on FP/RH, including safe motherhood, using local traditional themes. Drama troupes underwent training and performed for youth audiences at the Sawa Camp and the youth centers reaching an audience of over 26,000 youth.
- An educational video in local language focusing on HIV/AIDS prevention was produced using local technical experts. The video is just now being shown to initial audiences.
- Sawa Camp FP/RH educational sessions were held for over 26,000 youth.
- A formal referral linkage was established between NUEYS and MOH facilities. As a result, 67 youth were officially referred to MOH facilities for treatment and consultation.
- One nurse from the youth health center in Asmara and two military personnel at Sawa Camp were trained in clinical FP service provision and counseling.
- In collaboration with UNFPA and the MOH, 5,760 CYP were generated at Sawa Camp and the NUEYS health center.
- 175 NUEYS members in three zones were trained in peer counseling. The initial target was to train 60 peer counselors, but demand resulted in the target being nearly tripled.

- SEATS assisted in leveraging support from PATH and UNFPA for the purchase of a small printing press for NUEYS which has been used to produce IEC materials and to generate income for the organization.
- Three members of NUEYS senior staff, including the chairperson, attended a SEATS-supported NGO sustainability workshop in Cote d'Ivoire, resulting in the development of a sustainability strategy for NUEYS.

The NUEYS activities supported by SEATS helped to increase the support and approval of the government and the public for youth RH interventions and increased the quantity and quality of RH information and materials available to youth.

E. Service Delivery Systems

SEATS support to expand and improve service delivery systems spanned the three major components of the Eritrea program. Efforts were focused on upgrading facilities/service delivery points, enhancing the quality of services and improving logistics and health information systems .

1. Upgrading Facilities

SEATS improved 100 health facilities, procuring and distributing furnishings including tables, chairs, benches, and patient beds. Medical equipment including examination and delivery beds, delivery kits and infection prevention equipment was supplied. Renovation work was carried out in the five health facilities that were used for practical training sessions. Improvements included extension of running water systems and installation of hand-washing basins to reduce the risk of infection transmission. Other clinics duplicated the improvements (e.g., four health facilities introduced running water for hand washing and 69 health facilities provided washing basins).

A situation analysis of health facilities/hospitals in the three USAID focus zones was done by SEATS and the MOH to ascertain their readiness to support essential obstetric care. As a result, physicians are now undergoing emergency obstetrical care training by apprenticeship and equipment to improve delivery services has been purchased. Mechanisms to link peripheral health facilities with the large zonal hospitals by radio network are under feasibility study.

2. Quality

SEATS and University Research Corporation (URC) conducted quality assurance training for 50 MOH senior staff from the central office and zonal health management teams (ZHMT) using CQI methodology. The MOH then adapted and used the methodology in training over 900 officials, of which 675 were trained with SEATS' direct support. SEATS assisted with the preparation of a Manual for Quality Improvement Methods based on the tools and methodology adapted from the SEATS and URC training.

Trainee follow-up tools were developed and used to conduct objective post-training assessment of 68 trainees. Use of the follow-up tools showed that, after family planning training, providers were better integrating FP with other primary care services such as immunization and maternal care. At many clinics, providers had improved their infection prevention practices.

SEATS introduced instruments for a baseline survey on QOC. Adapted from the Quick Investigation of Quality (QIQ) instruments developed by the MEASURE Project and USAID's Maximizing Access to Quality (MAQ) Initiative, the survey tools consisted of a facility audit and a community survey.

- The facility audit was undertaken at 13 health stations. It sought to determine whether there was adequate space for physical examinations and for clients to wait and if essential equipment was in place and in working order. The audit also examined if there was an adequate stock of contraceptives and other supplies and if IEC materials and clinical protocols were readily available. The system of soliciting input from clients was evaluated, if one was in place.
- The QIQ instrument for client interviews was adapted for use as a community survey. Approximately 1,400 men and women surrounding the health facilities were surveyed. Both users and non-users were asked KAP questions. Users were asked questions on their present and past FP method usage and their satisfaction with services. Non-users were asked why they were not users. There were also questions related to AIDS, STIs and condoms.

SEATS and the MOH sought to upgrade the quality of reproductive health care, including maternity care, using a CQI approach. The National Quality Policy Guidelines were completed and a task force was set up to oversee the introduction of CQI countrywide and to develop a training guide for the introduction of QA/CQI activities.

CQI training was conducted in all six zones - the Northern Red Sea, Anseba, Southern Red Sea, Gash Barka, Debub, and Maekel. Zonal quality teams were formed in four zones and quality teams will soon be operating in the other two zones. Local community members and administrators were involved in the definition of quality in seven sub-zones of Maekel zone and, in other zones, mechanisms are in place to involve local administrators. Health facilities are in the process of forming quality teams that will identify issues to be addressed; identify strategies; implement activities and then report to the overall zonal quality teams on progress.

> *"Since the liberation eight years ago, I have never attended any kind of workshop and this is the first and the best I could have attended. It gave me a lesson that our clients are the center of our services. I will brief my work colleagues who have not had this chance and I recommend that this training should reach all health professionals."*
>
> -Eritrean Service Provider after attending SEATS quality training

3. Logistics and Management Information Systems

SEATS was requested by the MOH to help improve the management and sustainability of FP and RH services through the development of contraceptive logistics management information systems (LMIS). In response, SEATS supported a baseline assessment of the Eritrean Health Logistics System in 1996. Experts in logistics management from the USAID-funded Family Planning Logistics Management (FPLM) Project, also implemented by John Snow, Inc., and SEATS' Africa Regional Office in Harare, Zimbabwe assessed the systems in place nationally and in the zones. From this assessment, a variety of support needs and activities were identified. Subsequently:

- The MOH held discussions with all agencies involved in providing FP services to assess the need for commodities and then procured the required commodities. The Planned Parenthood Association of Eritrea (PPAE), USAID and UNFPA collaborated in this effort. The MOH, through the Central Medical Stores (CMS), continues to forecast needs and procure commodities. Paradox software was installed at CMS for use in forecasting.
- CMS adopted a pull (based on demand) system of commodity distribution, rather than the previous push (based on available commodities) system.
- The CMS warehouse was renovated and increased staffing of the medical stores occurred at all levels.
- SEATS provided computers, printers, back-up facilities and fax modems for all six zonal medical stores.
- Five pharmacists in charge of the regional stores were trained in basic computer principles and ten were trained to use Paradox software to forecast and maintain information at their respective stores. Efforts are underway to link all the zonal stores with an e-mail system.
- The transportation system to the zones was improved and long delays eliminated. The zones now have a budget for transportation and negotiate directly with transporters.
- Forms for better information management were designed and are in use. Client cards and attendance registers were introduced at facilities. Client referral forms were adapted from PPAE. Commodities distributed by clinics are now reported to the national health system. Requisition forms for ordering commodities and quarterly stock balance reports are used by zones
- New warehouses to be constructed in the three USAID focus zones are being designed.
- In November 1999, SEATS sponsored a three-person team from FPLM/Kenya to work with the Pharmaceutical Services Division of the MOH to conduct an evaluation of the software and logistics management system. Recommendations have been given to the MOH for future interventions.

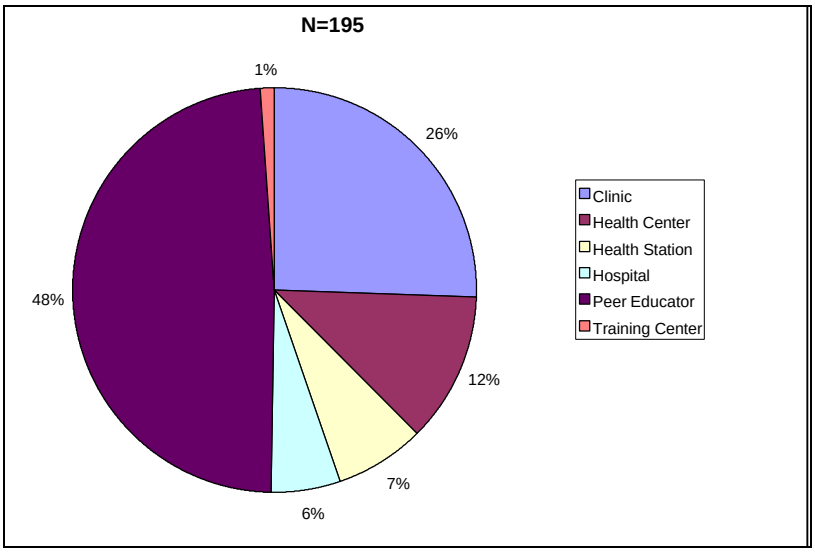
VI. ACCOMPLISHMENTS AND CONSTRAINTS

The previous section (V. Implementation) outlined very briefly the activities SEATS supported in Eritrea. It is important to consider the overall contributions SEATS II has made to Eritrea's national FP and RH programs and what value SEATS has added toward the achievement of USAID's Objectives.

A. Improved Access to Reproductive Health Services

With SEATS' support, 195 service delivery points were established or improved in an effort to increase the quality of FP/RH services and improve access. Forty-six facilities - hospitals, health centers and health stations - were equipped with substantial amounts of equipment. In these and others, health workers, nurses and health assistants were trained in basic skills for FP service delivery. Health stations that before were only providing condoms now have staff counseling for all methods and provide Depo-Provera®. Nurses capable of providing IUDs have been deployed to some of these facilities. Chart 1, below, shows SDPs by type.

Chart 1. Type of New and Improved SDPs in Eritrea



The involvement of TBAs and other community-based health workers in integrated health service delivery increased their awareness of available services and the information they could provide to the public. IEC strategies were designed and are being implemented which have helped to increase awareness of where to go for various services in the community. The combination of enhanced FP/RH IEC activities and deployment of skilled staff to the rural facilities has increased people's awareness of FP/RH issues and the choices they have available in services.

With 79 midwives trained in life-saving skills (LSS) and 146 other health workers oriented to safe motherhood and LSS, there are now more staff capable of responding to women in need. Many facilities are now staffed by LSS-trained providers.

The decision of the MOH to train physicians in emergency obstetrics was an important advance for safe motherhood. Pregnant women requiring surgical intervention are now managed in the regional hospital, reducing the need to refer them to faraway facilities. Efforts are being made by the MOH to equip hard-to-reach areas with radio transmission/communication equipment to facilitate sending ambulances and calling for emergency help when a situation warrants.

CYP

An objective to generate 30,000 CYP in the target sub-zones was achieved. This can be attributed in part to: 1) increased use of FP as a result of more SDPs providing a variety of methods and more staff trained in basic FP clinical skills, and 2) increased awareness resulting from SEATS IEC activities. Table 1, below, shows the CYP generated by quarter.

Table 1. CYP Generated by Year and Quarter

YEAR	Q1	Q2	Q3	Q4	TOTAL
1996	1436	1578	1826	1938	6778
1997	2243	3570	2861	3115	11,789
1998	1857	1958	1846	1841	7502
1999	1869	1345	2311	1813	7,338
Total					33,407

B. Improved Quality

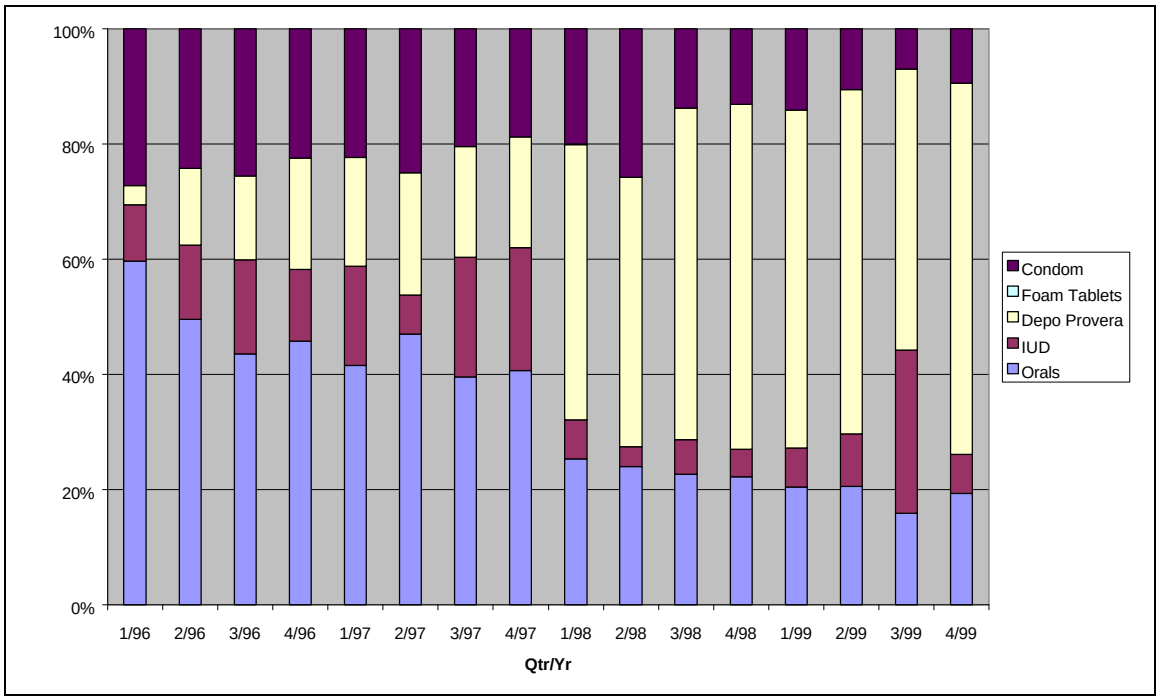
1. Family Planning

Quality was an essential part of SEATS' activities in Eritrea, and SEATS introduced QOC principles based on the Bruce-Jain Framework. Application of the Bruce-Jain framework for quality improvement included:

Choice of methods: To improve the method mix and give couples access to a variety of contraceptive choices, SEATS worked with MOH training staff on contraceptive technology updates. This training enabled service providers to broaden the method mix available and simultaneously improve communications with clients. Health stations in the three USAID focus zones started providing IUDs (where nurses were deployed) and Depo-Provera® to clients.

Analysis of the contraceptive method mix at the end of the project revealed a shift away from short-term methods to longer-term methods. In 1996, condoms and pills accounted for 74 percent of CYP, while Depo-Provera® and IUDs accounted for only 26 percent. By quarter four of 1999, this scenario had been completely reversed with condoms and pills accounting for 28 percent, and the longer-term methods (IUDs, Depo-Provera®) accounting for 71 percent of CYP generated up to December 1999.

Chart 2. Contraceptive Method Mix Expressed as Percentage of Total CYP



The shift in the method mix could be attributed to the training of more staff, nurses and health assistants, and the availability of IUD-trained providers and Depo-Provera® at health stations and health centers.

Counseling and client information: Clients need adequate information and counseling on the full range of family planning methods in order to assure informed choice. The training of health workers and TBAs was one strategy used by the MOH to reach communities with counseling and information. Posters and counseling aids (e.g., flip charts) were developed, distributed and used by newly trained service providers.

Technical competence of providers: SEATS assisted the MOH in capacity building of health professionals. A training of trainers (TOT) course was held for 19 nurses, who then provided training to other health professionals. New skills have led to improved infection prevention procedures in facilities and have enabled staff to provide IUDs and Depo-Provera®, thereby expanding choices for clients. Zones now have the capacity to conduct in-service training and supervision of RH services. They also conduct training of health staff in integrated PHC services and provide support to TBAs and other community-based health agents.

Client-provider interaction: SEATS, BASICS and the MOH collaborated to improve the skills of MOH staff in interpersonal communication. All six Zonal Health Management Teams have been trained in IPCC. Trainers used an interactive and participatory approach in which the teams planned formative studies, designed communication materials, and used the new approach in interacting with clients. The ZHMTs held training for health facility heads and other health workers and overall, in collaboration with BASICS, about 400 staff had been trained. Better client-provider interaction has led to increased client satisfaction. There are instances where community members commended health workers for changed attitudes. Feedback from clients

was that they could not believe that these health providers were the same ones who served them before.

Mechanism to promote continuity: SEATS collaborated with the pharmacy department of the MOH and installed a functional logistics management information system. A LMIS assessment was done with technical assistance from SEATS and most recommendations were implemented. Computers with suitable software for forecasting and managing stocks were put in place in all of the regional stores, as were mechanisms to ensure continuous availability of commodities. The MOH has been reviewing plans to ensure supplies at the community level, but this challenge has not yet been fully addressed.

Acceptability and appropriateness of services: SEATS and the MOH made efforts to respond to the needs of clients. Improvements were made in the clinics to provide privacy. The FP/RH services were integrated with other MCH activities. Services were provided on a daily basis and when requested. With specific emphasis on youth, services were integrated with vocational programs. The youth-friendly approach was accomplished by incorporating the FP/RH services into recreation centers. This enabled youth to use the services with confidence and with no stigma.

2. Safe Motherhood

Quality considerations were especially prominent in the Safe Motherhood Initiative. The MOH developed The National Safe Motherhood Clinical Management Protocol with technical assistance from SEATS. The Protocol offers guidance to service providers at different levels of care. Studies elsewhere have shown that maternal deaths can be avoided if standard maternal health care is provided; implementation of the Protocol should contribute to the reduction of maternal mortality in Eritrea and will provide guidance on quality standards.

The MOH has increased quality essential obstetric services through the following approaches:

- Increased training: A training program for physicians in emergency obstetrics has been initiated. LSS training of midwives strengthens the ability of staff at health facilities to manage essential obstetric care, and this will be further enhanced when the health assistants are also trained in LSS.
- Improved equipment at health facilities: SEATS provided 46 health facilities with basic essential delivery equipment including delivery beds/couches, delivery instruments and sets, examination equipment, and infection prevention materials.
- Community sensitization activities using enhanced IEC approaches: A safe motherhood communication strategy was put in place. Enhanced use of interpersonal communication and radio helped to advocate for care of pregnant women. Demand was created for safe motherhood and other PHC services through increased awareness and improved information.

C. Sustainability

One of the possible shortcomings of projects initiated and implemented through external assistance is that continuity of activities and achievements after the projects' closure may not be

assured. SEATS collaborated closely with the MOH throughout to maximize the possibilities of sustainability. In nearly all activities in which expatriate technical assistance was provided, the MOH appointed an official counterpart whose management and training skills were developed continuously. Increasingly, the MOH has staff capable of carrying out most of the functions that have been supported by SEATS. Chart 3, below, shows the range and magnitude of SEATS training in Ertirea.

In addition to institutionalizing program management capabilities, 19 nurses and nurse midwives were trained as trainers in basic FP. The trainers are MOH staff located both centrally and in the zones. Their involvement in training increased as project activities progressed. They acquired mastery of the curriculum. Most of them are also clinical instructors at the national health training institute and will continue to act as training resources.

Local obstetricians were also involved in training, leading special training sessions and participating in the overall management of the program. Such on-the-job experience in training and improved service delivery increases the in-country capacity which remains available once the project has ended.

The MOH also restructured its operations and staffing. A Community and Family Health Department was created. The senior obstetrician deployed to head its operations participated in CQI and IPCC training. The unit has developed a five-year workplan with a budget for community and family health services. Discussions have been initiated with UNFPA, UNICEF, and WHO to identify specific support those agencies could give to the unit's FP/RH programs initiated with SEATS' assistance.

MOH and NUEYS staff attended quality and sustainability training provided by SEATS in Harare, Zimbabwe and have subsequently been applying the principles of sustainability and leveraging of resources in the design of projects.

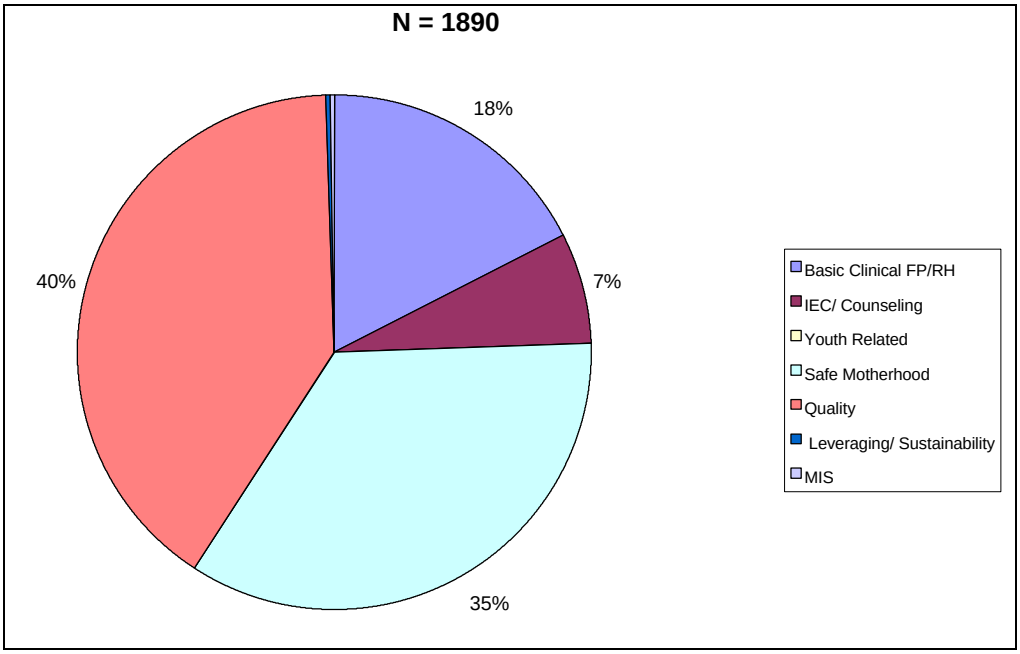
> NUEYS has written a number of proposals and has received funding for youth RH programs. They supplement the money they receive with other funds leveraged through their own income-generating activities such as a lottery, taxi service, and salt export business. Approximately 15 percent of funds received from income-generating activities are used to support health-related programs.

With SEATS' assistance, the MOH established a group of ten qualified life-saving skills trainers. The trainers were drawn primarily from training institutions – the school of midwifery, the school of nursing and the school of health assistants. The trainers are a resource that will continue to be available in country and that the MOH can draw upon for both initial and refresher training of midwives and other health staff. The obstetricians currently posted to the large hospitals will continue supporting capacity-building efforts for both other physicians and midwives.

The MOH plans to integrate LSS into both pre-service and in-service training for health assistants. Training and health professionals will review and design new curricula for training this cadre of staff. This strategy will ensure the expansion of the number of skilled staff who can provide safe motherhood services to the community. The MOH developed National PHC Policy Guidelines that specifically support efforts to create demand for RH services. The MOH has set as its main

target the reduction of maternal mortality by 50 percent in the next five years by providing support to safe motherhood programs. It will continue to allocate financial resources to reach this goal. The MOH has held discussions with UNFPA and SEATS to identify resources that UNFPA might provide to support RH activities, particularly the LSS training, after SEATS.

Chart 3. SEATS Training in Eritrea (by percentage)



D. Constraints

The constraints to SEATS' implementation efforts in Eritrea can be summarized under five major categories: 1) challenges of a new government; 2) MOH management and implementation capacity; 3) low priority of some RH components; 4) the physical environment and its effect on communications; and 5) the renewed outbreak of the Ethiopian-Eritrean war.

1. Challenges of a new government

The Government of Eritrea is new, facing all the challenges of any nascent government. In addition to internal struggles to rebuild infrastructure and meet the needs of the population after years of war, the government must look outward to build relationships with other countries, international institutions and assistance organizations. Cumbersome administrative, reporting and financial requirements frequently accompany international development assistance. The new GOE is fiercely independent and has insisted on retaining a high level of control on all development inputs. The time and effort required to understand and accept or negotiate the operations of USAID CAs such as SEATS and the technical assistance procedures (scopes of work, reporting needs, financial processes, etc.) are considerable and occasionally led to delays in program implementation or to mid-course changes in administrative and management arrangements in country.

2. MOH management and implementation capacity

Some elements of the MOH operating systems led to difficulties in project implementation. Changes in funding policies, high turnover of senior staff, limited availability of staff for training and cumbersome authorization processes sometimes caused lengthy delays in implementation. Rescheduling and even cancellation of some activities (e.g., peer counselor refresher training with NUEYS) meant that not all project objectives were met in a timely manner or at all. Changes in MOH requirements regarding the funding of some project components resulted in complete cessation of programmed safe motherhood activities with NUEYS for one year. Constant dialogue with the MOH helped to remedy some of the problems.

3. Low priority of some RH components

Family planning training and programs were not a high priority for the MOH. The desire to have a larger population was voiced by several senior GOE officials. This led to modifications in training plans such as centralizing anticipated zonal training in order to have a sufficient number of trainees. It also led to some delays in training while negotiations for approval were held with MOH officials. Efforts to address FP within the context of reproductive health and safe motherhood helped to reduce opposition to activities and training.

4. The physical environment and its effect on communications

One of the USAID focus zones, Debub, had no access to telephone, fax or e-mail services. Some of the target health facilities were located in areas of difficult terrain with no paved road network. This created problems in communication and planning. Only very advanced planning and use of every avenue of communication helped to minimize the difficulties, which were not entirely alleviated.

5. Outbreak of the Ethiopian-Eritrean war

As fresh hostilities arose between Eritrea and Ethiopia and war broke out, a number of Eritrean staff were re-deployed from their regular posts and mobilized for national security service. Two of the three USAID focus zones were on the disputed border. Training sessions were delayed (e.g., LSS and FP training) or cancelled (e.g., community-based IEC training); supervisory activities were curtailed; and many MOH staff were re-assigned to urgent curative service in conflict areas. As a result, training targets were not fully met. Expatriates, including the SEATS resident advisor, were evacuated from Eritrea from June 1998-June 1999, further delaying implementation of planned activities.

VII. KEY LESSONS LEARNED

Each major activity implemented under SEATS' assistance to the EHP Project has generated lessons learned, best practices and innovations that can help guide future RH planning and programming in Eritrea. These are described in detail in individual subproject and activity reports listed in the references at the end of this report. For this Final Country Report, however, only a few have been selected as the most significant or noteworthy.

A. Training

Where there are determined people, learning/training can continue even under difficult circumstances. Despite initial difficulties, the MOH allowed SEATS to provide support for basic FP clinical training for nurses and health assistants, even at a time when the country was engaged in a border war with Ethiopia. Staff were released from health facilities that were in the disputed areas to attend training. The various government units continued to learn new skills even under the emergency and were determined to succeed, even in time of crisis.

FP and IPCC training motivate service providers. The health assistants and nurses who participated in IPCC and FP training were observed to take extra interest in their work, communicating more with clients and better satisfying clients, thus ensuring better outcomes such as improved compliance and sustainability.

Teaching materials for health workers should be made in local languages and be culture-specific. During LSS training and orientation, sessions were best understood when facilitators used *Tigrigna* language to explain sections of the National Safe Motherhood Clinical Protocol and the LSS training guides. Training in Eritrea is typically done in the local language. This calls for making teaching materials in the local language too.

B. Service Delivery

The material requirements of service delivery staff increase with training. After FP training, the health assistants and nurses in the health stations and health centers made requests for supplies to ensure better infection prevention practices. Their desire to broaden the method mix and contraceptive choices for clients led to additional supply and commodity requests. After LSS training, the midwives identified shortfalls in the services they were previously providing. Subsequently, they made requests for supplies to improve infection prevention and for other equipment that would enhance care for the women in labor.

LSS leads to a change in attitude of staff that improves the quality of services. It was observed that service providers were communicating more with clients during the different stages of pregnancy after LSS training. This new attitude and behavior was likely to enhance client compliance and ensure better outcomes.

Successful programs may influence changes in official policies. The success of the safe motherhood program, especially LSS training, and sensitization to the level of maternal mortality

in Eritrea led to a change in the policy of the MOH concerning the training of health assistants. This cadre of service providers was previously not expected to assist with deliveries. After the benefits of LSS training were realized, the MOH decided to initiate a training program for them on the critical elements of midwifery to ensure that they are proficient in managing women in labor.

C. Sustainability

For continuity of a national program, the commitment of central MOH officials is essential. Senior MOH officials recognize the importance of the safe motherhood program and have started leveraging resources from UNFPA for training of physicians in emergency obstetrics (ongoing) and for LSS training for midwives in additional zones. The MOH also plans to integrate LSS training into both pre-service and in-service training for health assistants and other health workers. This strategy will expand the number of skilled individuals who can provide safe motherhood services to communities to improve maternal health in Eritrea.

VIII. RECOMMENDATIONS

The lessons cited in the section above suggest directions and approaches that SEATS recommends the GOE and USAID/Eritrea consider in future FP/RH programming. Reports cited in the list of references for this document include many recommendations addressed to specific partners in Eritrea. Some of the more notable and/or urgent recommendations are set forth below:

- The MOH designed a good structure within its PHC unit for the implementation of community and family health activities, including FP. However, there is no focal person whose sole responsibility is FP training and supervision of FP service delivery. SEATS recommends that the PHC unit of the MOH assign a focal person to be responsible for FP/RH service delivery and monitoring.
- Careful planning and extreme sensitivity must be applied in determining development interventions in Eritrea. A participatory process must be adopted always, not only for identification and design of interventions, but also for tracking implementation progress and problems.
- To maximize the impact of RH interventions, donors and NGOs should design integrated programs that include child health. This might help reduce the resistance faced by programs that are exclusively dedicated to FP.
- Programs in Eritrea needed to be designed and implemented with flexibility. Workplans developed at the beginning of the project should be reviewed regularly in order to accommodate the rapidly changing needs of the MOH.
- Skills-based training (e.g., LSS) increases the motivation of service delivery staff to provide quality services that in turn require more supplies and equipment. Government, CAs and donors should always plan and budget for these increased needs before proceeding with training. If the additional needs are not accommodated, government and providers risk losing credibility and enthusiasm for the delivery of quality RH services.
- Key learning materials and guidelines (protocols, proclamations, curricula, etc.) should be produced in the languages commonly used in Eritrea so that trainees will better understand and use the materials.

Relevant Documents

Eritrea Demographic and Health Survey, 1995.

Continuous Quality Improvement Baseline Study. SEATS/Eritrea, 1999.

Report on Knowledge, Attitude and Practices of Family Planning, Antenatal Care and Delivery Services among Women of Reproductive Age in Eritrea. SEATS/Eritrea, 1999.

Mother–Baby Package: Implementing Safe Motherhood in Countries. Maternal Health and Safe Motherhood Programme, Division of Family Health, WHO, Geneva, 1996.

The MOH/Eritrea Safe Motherhood Communication Strategy, 1999.

The MOH/Eritrea FGC Eradication Communication Strategy, 1999.

Every Opportunity: Eritrea Family Planning Service Delivery Subproject Final Report, 1999.

Safe Motherhood Initiative Final Report, 1999.

Access for Youth to Family Planning/Reproductive Health Service Delivery Final Report, 1999.

Appendix I
Map of Eritrea